Hamilton Niagara Haldimand Brant **LHIN**

Quality care in community hands. Planning for the future.

2007-2008 Annual Report

Local Health Integration Networks – The Evolution Continues

The 2005 launch of Local Health Integration Networks marked a wave of change in health care in Ontario. No longer would our health care system be centrally managed. Instead, 14 Local Health Integration Networks (LHINs) would be responsible for planning, integrating and funding the health services in hospitals, long-term care homes, community health centres, community care access centres, community support services, and mental health and addictions services within their respective borders.

The benefits of the LHIN model are many. Health care planning and decision making are done close to home so that local needs can be identified more easily. LHINs enable continuous and meaningful engagement with the communities they serve and the health service providers that deliver the care. And they allow for flexible solutions to meet community needs.

The early work of LHINs is grounded by an Integrated Health Service Plan (IHSP), a blueprint for early health improvement priorities. The HNHB LHIN IHSP (2006) was shaped by priorities identified in 2005 and informed by advice of community residents and health service providers. The LHIN Board and staff are now carrying out that plan in concert with health service providers and community members.

On April 1, 2007, LHINs across the province received funding authority and responsibility for monitoring local health service providers. This is our first annual report with our full mandate.

Table of Contents

The Hamilton Niagara Haldimand Brant LHIN

Vision

A health care system that helps keep people healthy, gets them good care when they are sick, and will be there for our children and grandchildren.

Mandate

To plan, fund and integrate the local health system to provide appropriate, coordinated, effective and efficient health services in Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk.

Mission

To ensure availability of, and access to, linked services in order to improve the health of the population and the continuity of health care.

Values

Respect; Integrity; Accountability.

We work from the approach of being a catalyst for change; with a viewpoint based on the individual, and their caregivers, who need to access local health services.

To achieve this we are committed to:
Transparency; Collaboration; Innovation; Real conversation.

Message from the Board Chair

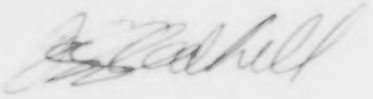
What a difference a year makes! The Hamilton Niagara Haldimand Brant (HNHB) Local Health Integration Network (LHIN) also serving Burlington and most of Norfolk, exercised its full mandate – planning, coordinating, funding and monitoring health services. The year marked the first series of local decisions for health improvement and the allocation of approximately $11 million to improve access to the right services at the right time for citizens. Allocations were aligned with the LHIN's Integrated Health Services Plan (IHSP, 2006), the Minister of Health's commitment to healthy aging and seniors' independence, and timely patient flow through the hospital system and back home. In addition, the LHIN approved the amalgamation of the Erie North Shore Support Services and the Canadian Mental Health Association offices in Haldimand for improved access to mental health and addictions services, the first integration in our communities.

Our residents, stakeholders and providers continue to confirm that good ideas for accessible, coordinated and effective programs and services lie in the community. Insights, knowledge and experience of consumers and experts alike have informed our local decision making. Speaking with and listening to citizens directly through service organizations, community events, provider open houses, annual general meetings, and education roundtables continues to be our priority. A special thank you is extended to all members of the public who have attended our Board meetings to bear witness to transparent local decision making.

The Board is proud to report that again this year it met all of its commitments to the Minister of Health and Long-Term Care. However, our success is your success and would not have been possible without the commitment and leadership among our communities. Whether it's new partnerships for healthy aging strategies, the action strategies of the Alternative Level of Care Steering Committee, or the LHIN-wide Maternal Newborn Steering Committee, relationships and collaboration are foundational for health improvement. Collaboration is improving access to quality services in the areas of work place health and safety, child health services closer to home, independent living in the community, concurrent disorders, palliative care, and reduced wait times for key services. In addition to client-centered services, our community continues to make strides with a LHIN-wide plan for integrated information and communication technology (ICT) which will ensure timely access to information for patient care, continuous quality improvement and system planning.

I extend my continued thanks to each of my Board colleagues, our CEO Pat Mandy and her team. Their time, dedication, hard work, and in particular their commitment to local decision making has sustained commitment among all LHIN stakeholders to shape a health system that keeps people healthy, gets them good care when they need it, and is there for our children and grandchildren.

It remains an honour and a privilege to serve the citizens of Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk as Chair of our LHIN Board.



Juanita G. Gledhill

The HNHB LHIN Board of Directors


Juanita G. Gledhill

Appointed: June 1, 2005 • Term: 3 years
Re-appointed: June, 2008 • Term: 3 years

"This year saw our board and community realize the early possibilities of local community decision making as our Board made its first funding allocations for urgent priorities in our local health care system. We also launched the planning and initial funding for the Aging at Home Strategy: decisions informed by our community and made by community members."


Jack Brewer

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Re-appointed: June, 2008 • Term: 3 years

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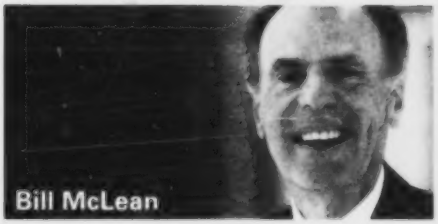
Bill McLean

Appointed: May 17, 2006 • Term: 2 years
Re-appointed: May 17, 2008 • Term: 3 years

"I am very proud of the fact that the HNHB LHIN board makes its decisions in open board meetings with members of the public in attendance. This transparency in decision making is welcomed by both health care providers and the general public and is a refreshing difference from most decision making organizations."


Bill Millar

Appointed: March 7, 2007 • Term: 2 years

"I have served on the LHIN Board for a little over a year and I continue to be impressed by the unique promise the LHIN concept holds for renewing and sustaining our health system. The notion of a body which can take a broad perspective on local health care, seek out and reflect the ideas and concerns of providers and consumers, encourage integration of services, monitor and promote quality and ensure appropriate accountability is a powerful one."

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Re-appointed: February 5, 2007 • Term: 3 years

Appointed: June 1, 2005 • Term: 3 years
Resigned: June 24, 2007

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Message from the CEO

While 2007/08 was our second full year in operation, it was a year of firsts for Local Health Integration Networks (LHINs) across the province as we embarked on the first year of our full mandate. This milestone was marked early in the fiscal year on April 1, 2007 when LHINs received the funding authority and responsibility for health service providers.

This dramatic shift in accountability was embraced by our team as an opportunity to evolve and refine the organization and delivery of health care to the citizens of Hamilton, Niagara, Haldimand, Brant, Burlington and Norfolk. The diverse knowledge base and skill set of the HNHB LHIN staff have ensured that funding recommendations have been informed, transparent and collaborative. Staff worked closely with health service providers on a number of occasions to ensure health care investments were informed by the providers and community members and were maximized for our communities and stakeholders.

Our LHIN is fortunate to have people and communities willing to participate and collaborate. While we have had many success stories, there are some key accomplishments during the past 12 months of particular note:

- Working with a variety of health services providers in the Niagara region, LHIN staff encouraged a collaborative proposal that resulted in the allocation of more than $1 million in Emergency Department Action Plan (EDAP) funding to enhance community-based services to be able to expedite patient flow from Niagara hospitals.
- Allocation of LHIN Urgent Priority Funding (LUPF) for health improvement opportunities was a process that saw more than 40 proposals from approximately 30 health service providers in our LHIN receive $2.9 million. Over the course of four Board meetings, staff brought to the Board more than 100 proposals for their consideration.
- Prior to the establishment of LHINs, annual surplus dollars were returned to the Ministry and redistributed across the province - local health care dollars were leaving our community. This past year, HNHB LHIN staff worked with all providers to identify surplus dollars early and reallocate them to other providers to enhance services in our LHIN. Those health care dollars continued to work for the citizens of our LHIN.
- In August, 2007 Minister Smitherman visited the Winona Seniors Club as part of the Aging at Home Strategy and announced that more than $60 million dollars would be coming to our LHIN over three years to enhance seniors' choices to sustain their entitlement to live with dignity and independence in their own communities.
- The voluntary integration of Erie North Shore Support Services and the Canadian Mental Health Association office in Norfolk was a first for our LHIN. These two organizations worked together (and with LHIN staff) to identify the benefits and efficiencies that could be realized by coming together as one organization. This successful integration will be a model for the future.

Our Team continues to play a role shaping policy and practices among LHINs at the Provincial level for health improvement. Our staff have contributed to Province wide approaches to implementing the aging at home directions,

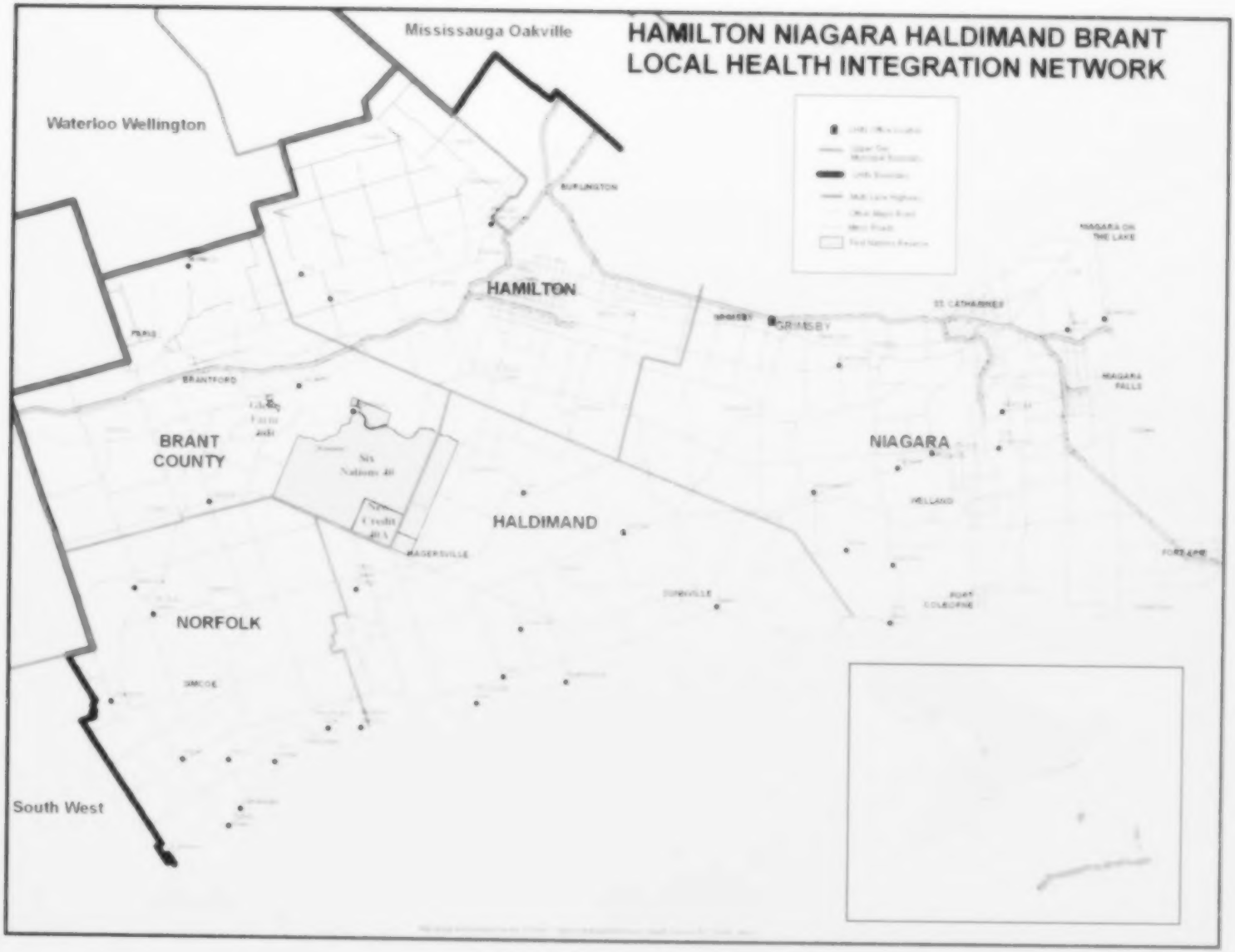
the development of indicators for measuring success, meaningful approaches to relationship building with aboriginal communities, and developing strategies to address alternate levels of care pressures.

Throughout this report you will find many more success stories that are helping to provide the foundation to the growing legacy of the organization. Successes such as these give reinforcement to the mandate and tools by which we continue to build relationships and advance positive change for our local health system.

In closing, I would like to acknowledge the dedication, leadership and vision of our Board of Directors who continue to invigorate and inspire the entire organization. I also thank the Chair for her tireless commitment and passion for health system improvement.

Pat Mandy

Please visit the Hamilton Niagara Haldimand Brant LHIN website at www.hnhblhin.on.ca to find out more about how we can work together to improve the integration, quality and outcomes of health services in our community.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Waterloo Wellington
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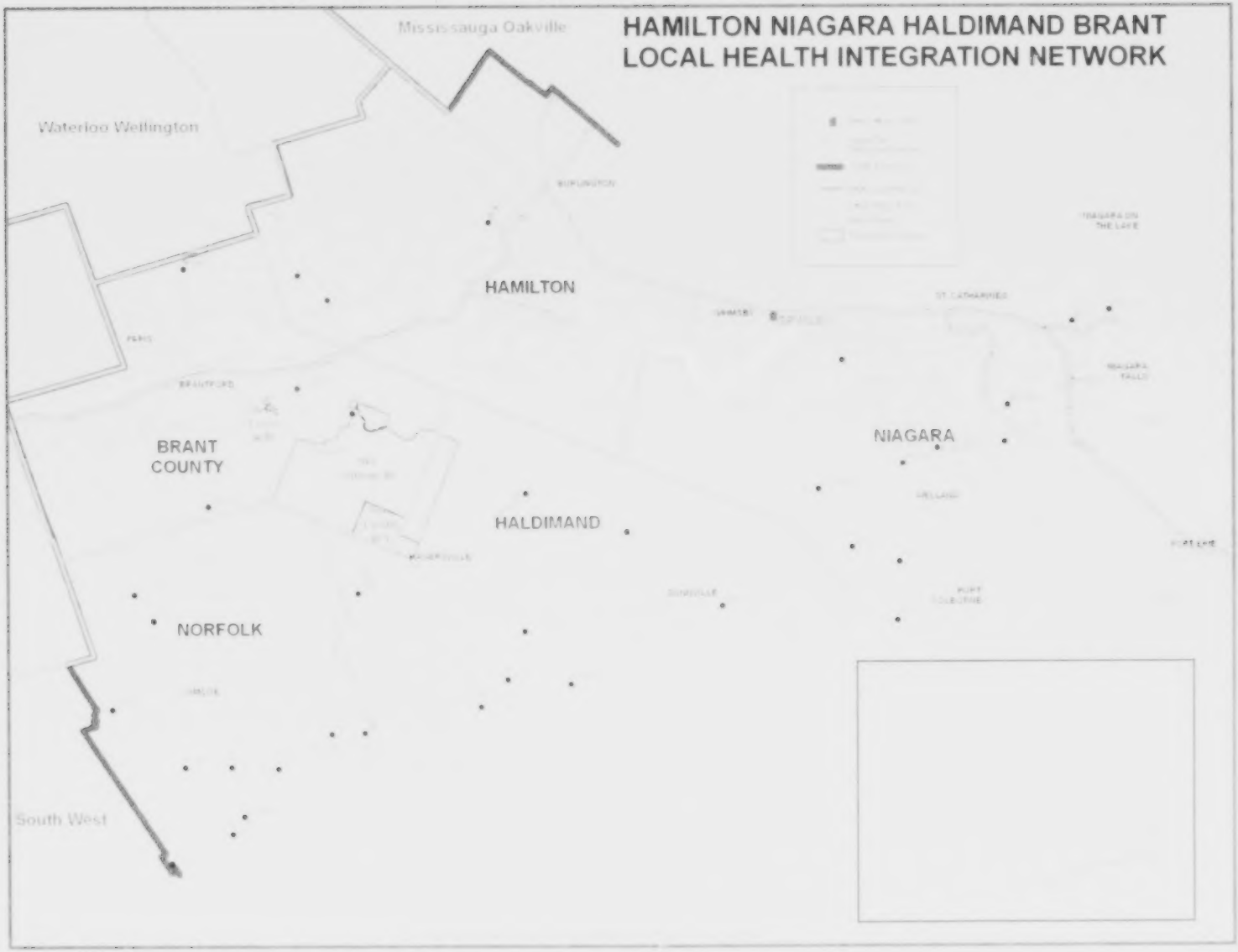
NORFOLK
South West
BRANTFORD
GRIMSBY
ST CATHARINES
NIAGARA FALLS
NIAGARA ON THE LAKE
WELLAND
PORT COLBORNE
DUNNVILLE
SIMCOE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Our Hamilton Niagara Haldimand Brant Local Health Integration Network (HNHB LHIN)

The HNHB LHIN is representative of Ontario. It is characterized by urban and rural communities, a changing demographic rich in ethnocultural and linguistic diversity, variable incomes and levels of education achievement, and a mixed economy in transition. The LHIN's population mosaic is also enriched by two Aboriginal reserves - Six Nations of the Grand River Territory and Mississaugas of the New Credit - and a significant Francophone population.

Our challenges are great. The HNHB LHIN population at 1.4 million is the second largest LHIN in the province overall. Rates of aging, poverty, single parent families, and low educational achievement are above Ontario averages. There is considerable room for health improvement in the areas of smoking cessation, healthy body weight, addictions prevention, workplace health and safety, and safe driving. Chronic disease prevalence, persons living with diabetes, and incidence of cancers are together shaping a health action agenda for better health outcomes.

Our LHIN...

Serving the communities of:

- Hamilton
- Niagara
- Haldimand
- Brant
- Norfolk
- Burlington

At the same time, opportunities abound. The HNHB LHIN is rich in assets, including a world renowned Faculty of Health Sciences at McMaster University, research and learner communities in Niagara, Hamilton, and Burlington, and collaborations and networks for health system improvement. Aspirations are alive for healthy communities and we see it in Hamilton's commitment to being "the best place to raise a child" and in the Niagara Region's pledge of "Building Community. Building Lives."

Together, LHIN communities are taking on the challenge for a health care system which keeps people healthy, gets them good care when they need it, and is there for our children and grandchildren.

2007-2008: A Year in Review

March 2006 saw the proclamation of the Local Health System Integration Act (LHSIA) which formally assigned to LHINs the mandate to plan, integrate and fund local health services. The next step in the evolution of health care in Ontario was reached on April 1, 2007 when LHINs were given full responsibility and authority for decision making related to health care funding. On behalf of our communities, the HNHB LHIN Board made decisions related to advancing the Integrated Health Services Plan (IHSP) priorities, healthy aging and independent living and reallocations among providers to sustain programs and services. While the government (through the Ministry of Health and Long-Term Care) will continue to set strategic directions and provincial standards for high-quality, accessible health care, LHINs now have greater responsibility and accountability for funding community health services.

Continued Evolution of the HNHB LHIN

Our Organization

The HNHB LHIN staff complement is growing in numbers and diversity. The range of skills, knowledge and experience have been honed in health and human service planning, funding and coordination, capacity development, epidemiology, performance measurement, project management, accounting, public health and communications. Staff is guided by the values and principles of the organization including respect, integrity and accountability, and to achieve this staff is committed to transparency, collaboration, innovation and real conversations.

2007-2008 saw a few changes to our Board of Directors.

Leaving the Board – Having served as one of three founding board members of the HNHB LHIN from June 1, 2005 Kim Stasiak resigned in June 24, 2007. We thank Kim for her involvement with the Board.

Joining the Board – On May 9, 2007, Douglas Archibald joined our LHIN's Board of Directors. A resident of Port Dover, Douglas brings considerable experience and expertise to the HNHB LHIN in accounting and information technology. Douglas was the founder, president and CEO of International Verifact Inc., one of Canada's "Top 100" Companies. Prior to his move to Port Dover, Douglas was active in his community with the Muscular Dystrophy Association, Oakville Summer Theatre, Lion Rampant Club, and Mother Teresa's Organization in Canada. We welcome Douglas to our Board.

Our LHIN Senior Leadership Team includes the CEO, Senior Director – Performance, Contract and Allocation and the Senior Director – Planning, Integration and Community Engagement.

Senior Leadership Team members attend the regular Board meetings and present monthly verbal and written reports to the Board on the activities in their respective portfolios. Led by the CEO, the Senior Leadership Team guides strategic operations of the organization.

The Board provides ongoing direction to the CEO through:

- Regular meetings
- Board committees
- Policy direction
- Performance appraisal

Connecting with our Communities

Community engagement and relationship building are integral to the work of the LHIN and all stakeholders if we are to achieve an improved health system. The LHIN continues to engage health service providers not only with the LHIN organization but with each other for collaboration and solution building. At the same time, we continue to be reminded that health is more than health care and that health improvement solutions will benefit from collaborations among a broad range of health and related providers.

The LHIN's reach extended to local area and regional funders, who as well contribute to health care activities; these include the United Ways, municipal and regional governments, community foundations and civic clubs. The LHIN community engagement team partnered with gerontology students at McMaster University to engage conversations with communities about supports for healthy aging. The LHIN is participating in poverty improvement initiatives and human services planning in Hamilton, to learn how integrated human services planning can contribute to improved organization and distribution of health care services.

Of special note within the LHIN's mandated responsibility, are the activities underway to network with the French language, aboriginal and health professional communities in the HNHB LHIN.

> "Our communities must have collaboration, communication and coordination to work best and thrive."
>
> —Pat Mandy, LHIN CEO, January, 2008

The LHIN is working with an interim French Language Committee, a forerunner to the pending French Language Health Planning Entity. The interim committee offers advice to the LHIN on appropriate engagement of the French Language community, areas of importance for health access planning, and sources of intelligence.

In the summer of 2007, the LHIN began the process of developing the Health Professionals Advisory Committee (HPAC). The Committee, required by legislation, will advise the LHIN on key questions raised by community stakeholders related to the on-going implementation of the Integrated Health Services Plan (IHSP), and other strategic initiatives. Our LHIN received more than 70 applications of interest to serve on the Committee and an HPAC Review Committee, comprised of representatives from Brock University, Mohawk College, McMaster University and Hamilton Health Sciences reviewed the applications. A slate of candidates was recommended to and approved by the HNHB LHIN Board of Directors in February. The first meeting of the Health Professionals Advisory Committee took place on March 7, 2008.

Given a combined population of more than 24,000 on and off reserve aboriginal peoples, the HNHB LHIN is working with First Nations, Métis and urban aboriginal health and social providers, and community members. A Search Conference in February, organized by the aboriginal communities, set the stage for developing a health plan for the most desirable future of their community, a plan they can carry out themselves. The LHIN expanded its understanding of the broader determinants at play in the lives of Aboriginal peoples and the wholistic framework through which participants experience health and wellness. In addition to our local initiatives, the HNHB LHIN has been recognized by the Ministry for its leading role in provincial coordination of Aboriginal health planning and community engagement across LHINs.

Finally, the LHIN has a role to build the capacity of others to plan, coordinate and measure success. The LHIN staff continues to work with networks and how they can contribute to health goals in the LHIN. The LHIN staff is also preparing an approach to performance measurement that will help shape providers' approach to measuring success and their confidence to adopt the practice.

Working Together: Building an Integrated Health System

"Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

– Margaret Mead (1901-1978)

Health Service Provider Integration Initiatives

Our LHIN endorsed three voluntary integrations in the past year under Section 27 of the Local Health System Integration Act.

Erie North Shore Support Services

On July 16, 2007, Erie North Shore Support Services and Canadian Mental Health Association Haldimand-Norfolk Branch (a non-LHIN funded provider) signaled to the HNHB LHIN their intent to integrate. The intended goal was to improve access and outcomes to the community by providing a larger menu of community based mental health services. The voluntary integration was endorsed by the HNHB LHIN Board of Directors on August 28, 2007.

Focus on Healthcare Supply Chain Integration

The HNHB deliberated on the Focus on Healthcare Supply Chain Integration (FOHSCI) project among 18 hospitals in the Hamilton Niagara Haldimand Brant and Waterloo Wellington LHINs, and St. Michael's Hospital in Toronto. Eight of eleven hospital corporations in the HNHB LHIN were included. FOHSCI would be run as a not-for-profit corporation as part of an existing shared services entity (Mohawk Hospital Services). The goal was to align FOHSCI partners' service sourcing and purchasing with Medbuy's processes thereby increasing efficiencies and reducing duplication of effort among the hospitals. The HNHB LHIN Board endorsed the voluntary integration on January 25, 2008.

Council of Academic Hospitals of Ontario

Also on January 25, 2008 the Board endorsed the voluntary integration of 25 teaching hospitals – all part of the Council of Academic Hospitals of Ontario (CAHO) – to proceed with a two-year pilot project involving a group purchasing initiative. In the HNHB LHIN, the pilot project includes Hamilton Health Sciences and St. Joseph's Healthcare in Hamilton.

Integrated Health Service Plan (IHSP)

The Integrated Health Service Plan: Phase 1 was released in December 2006 and identified early priorities for health improvement. Communities of interest, health service providers, thought leaders and community members continue to work collaboratively for change. A summary of early, emerging (maternal newborn, patient flow, chronic disease prevention and management) and province-wide priorities for all residents follows.

Occupational Health and Safety

A screening tool for occupational health-related illnesses and injuries is being developed for pilot in community health centres and family health teams.

Child and Youth Health

The "Access to Better Care" study is underway at McMaster University Medical Centre in part to ensure access to improved child and youth hospital based care.

Mental Health and Addictions Service Access

- Agencies are developing best practice screening tools; St Leonard's and Canadian Mental Health Association Brant have adopted a common tool for concurrent screening.
- Integration and partnership opportunities among mental health and addictions services have been identified for improved concurrent disorders services.

- A training program for mental health and addictions practitioners for enhanced competencies in concurrent disorders is available through Niagara College.

Independent Living

The LHIN allocated $7.6 million to strategies to enhance healthy aging and independent living in the community.

Elder Care and Support

A map of services for frail elderly has been completed and a directional plan for priority specialized geriatric services was launched.

End-of-Life Care and Support

Ongoing strategies for improved end of life care have to date trained 129 family physicians/teams, and interdisciplinary providers in standardized tools for pain symptom management. In addition, more than 680 individuals have been oriented to the fundamentals of quality end-of-life care through a community partnership with the Department of Family Medicine at McMaster University.

Patient Flow

- Regular rotational access to 1A crisis pilot protocol.
- Three slow stream pilot projects successfully preparing patients for return home.
- Improved discharge planning.
- Provider and public education regarding lifestyle choices for aging persons.

Chronic Disease Prevention and Management (CDPM)

An action plan, led by two LHIN appointed CDPM leads, is underway with a focus on diabetes.

Maternal and Newborn Care

LHIN-wide recommendations tabled for improved maternal newborn care have led to provincial action on hospital nursery designations and capacity requirements, and LHIN wide hospital compliance with data tracking.

Integrated Communication Technology – e-Health

E-Health is an important means of engaging providers, patients, clients and other key stakeholders in the maintenance, management and delivery of healthcare in the HNHB LHIN. Progress on the e-Health Strategic Plan (2006) has been achieved through collaboration among health care providers in the LHIN on projects beneficial at the local and regional levels. Examples of progress include:

- The Diagnostic Imaging Repository project - a collaborative initiative between the hospitals in the HNHB and the Waterloo-Wellington LHINs that has seen the development of a joint project office working to realize the vision of real-time access to diagnostic imaging results and images.
- The Juravinski Cancer Centre at Hamilton Health Sciences and the planned cancer centre at the Niagara Health System participated in a joint cancer informatics project. The project will develop common patient data and communication standards to ensure seamless exchange of information between the two organizations.
- In Hamilton, the HNHB Community Care Access Centre (CCAC) piloted an electronic system for referral of its clients to home care providers.

Performance Measurement

A framework has been developed by the LHIN for measuring program, community and LHIN-wide goal achievement for intended outcomes.

Continuing the Dialogue - Community Engagement

- HNHB LHIN partnership with McMaster University Gerontology Department linking students with outreach to seniors.

- "Let's Talk" conversation tool to guide self directed conversations about healthy aging at home.
- Capacity assessment of networks for healthy collaboration and goal achievement.
- Engagement strategies for community health centre feasibility studies, maternal newborn planning, First Nations health planning, French language community and LHIN collaboration.
- Health Professional Advisory Committee (HPAC) membership confirmed.

Maternal Newborn Planning Project

In 2007, the LHIN initiated a maternal newborn planning project and the final report of the Maternal and Newborn Health Steering Committee was unanimously approved by the HNHB LHIN Board at its September 2007 meeting.

Recommendations from the report highlighted the need to ensure:

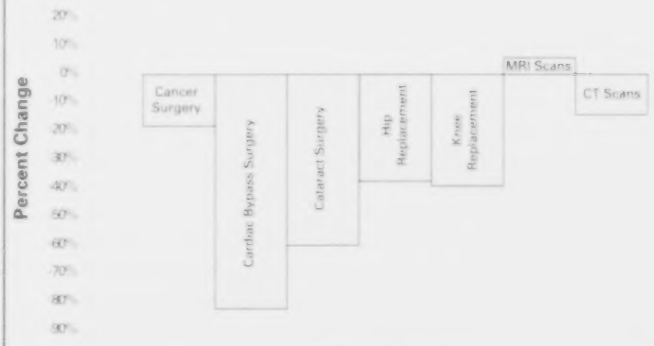
- hospital compliance with LHIN-wide data management strategies for continuous quality improvement;
- a review of hospital nursery designations that together support access, patient flow, and best practice and support; and,
- the adoption of collaborative practice models that enhance scope of practice, and guide training and development of maternity care providers.

At year's end, all LHIN hospitals are reporting data to the Ontario Bed and Resource Registry, the Ministry is reviewing hospital nursery designations in Ontario for access to best care, and health service providers across our LHIN and the Waterloo-Wellington LHIN are discussing collaborative practice models.

Wait Time Strategy

The HNHB LHIN continues to make significant progress in improving access to, and reducing wait times for the following health services: cancer surgery, cardiac procedures, cataract surgery, hip and knee replacements, and diagnostic imaging (MRI and CT exams). These successes are largely attributed to the work done through local partnerships with providers from the hospital and community sectors as well as the HNHB LHIN wait time strategy steering committee, its five associated work groups and other existing networks and committees, e.g. the Emergency Department Access Steering Committee and HNHB Alternate Level of Care (ALC) Steering Committee. In addition to the above services, the LHIN and its partners have been investing in strategies to improve supports and services in the community. Through these efforts the LHIN plans to prevent unnecessary emergency department visits, improve access to critical care services and reduce the number of people who return to hospital after having had a heart attack.

Wait Time Strategy 2007-08 Summary
Percent Change in Waiting Days
Quarter 4 (Jan-Mar) 2007- Quarter 4 (Jan-Mar) 2008



Note: A negative percent change represents a decrease in wait times.

Critical Care Strategy

Dr. Peter Kraus, Hamilton Health Sciences, was appointed by the Minister of Health and Long-Term Care as critical care leader for our LHIN. Meetings were held with critical care representatives (Program Director, Clinical Manager and Physician Lead) from each of the acute care hospitals in our LHIN to share the Critical Care Strategy for the fiscal year. Similar presentations were made to the HNHB LHIN office and to hospital CEOs, Vice-Presidents, Chiefs of Staff/Vice-Presidents Medical across the LHIN.

The Critical Care Strategy has realized a number of successes over the year, including:

1. Completion of the second year of Intensivist led Critical Care Response Teams (CCRTs) at Hamilton General Hospital, St. Joseph's Healthcare and McMaster Children's Hospital;
2. Initiation of a pilot model for an alternative CCRT at Henderson Hospital;
3. Advocating for an Intensivist led CCRT for St. Catharines General Hospital;
4. Launch of MOHLTC Critical Care Coaching Team projects at:
    a. Hamilton General Hospital (HHS) -End of Life
    b. McMaster University Medical Centre (HHS) - Systems Integration and Communication
    c. Joseph Brant Memorial Hospital- Data Management and Usage
    d. Niagara Health System - Patient Flow
    e. Norfolk General Hospital - Work-Life Improvements and Health Human Resources
    f. West Lincoln Memorial Hospital - Patient Flow
5. Allocation of two additional beds for chronically ventilated patients at St. Joseph's Healthcare;
6. Hosted three LHIN-wide teleconferences to discuss critical care issues and formalize the network;
7. All level 3 ICUs are now part of the Critical Care Information System (CCIS) database
    a. First quarterly report for first two reporting sites reviewed with LHIN CEO & Performance Integration Consultant: and CC representatives from reporting hospitals
    b. Reported back on above to provincial CC LHIN Leader roundtable

Emergency Department Strategy

In the summer of 2007 the Ministry of Health and Long-Term Care announced the creation of Emergency Department (ED) leads across the province. HNHB LHIN staff in consultation with key advisors determined the role of the Emergency Department Lead including expectations and goal setting. Dr. Bill Krizmanich accepted the position for the HNHB LHIN.

Dr. Krizmanich's first task was the completion of an Emergency Department environmental scan at each acute care hospital, working in collaboration with ED leadership teams at each site. These meetings occurred throughout the LHIN and included tours of the various emergency departments and looked at areas such as:

- Administrative structure;
- Type of emergency department and available statistics;
- Manpower and scheduling; and,
- Feedback on the role of LHIN ED Lead.

A key outcome of the environmental scans was the creation of scheduled HNHB LHIN ED leaders meetings, the first of which was held in November 2007. The focus of the meeting was to receive input and direction from our LHIN ED leaders with regards to the role of the LHIN ED Lead, MOH, LHIN and the ED Leadership for each department. Subsequent meetings have seen the establishment of a terms of reference for the meetings and a reporting structure, the completion of the "Narcotic Prescribing Policy" as a HNHB LHIN ED initiative, agreement to implement a common CME through the HNHB LHIN Emergency Departments, and the providing of regular updates from MOH regarding wait time strategy initiatives and emergency department reporting system.

In addition to the HNHB LHIN ED Leaders meeting, a presentation was made to the HNHB LHIN Chiefs of Staff with specific discussion related to reporting structure, ED wait time strategy update, and resource allocation for the HNHB LHIN.

Finally, a large HNHB LHIN ED Administrative meeting occurred in November 2007 to update the ED leadership on the Ministry of Health and Long-Term Care's wait time initiatives.

An anticipated province-wide Emergency Department Strategy funding announcement is expected in early 2008-2009. The directions from the MOHLTC will no doubt guide the future work of this group.

Celebrating Innovations in Health Care Expo 2007

Our LHIN was again well represented at the 2nd Annual Innovations in Health Care Expo – an event that showcased innovative solutions and projects supporting health care system renewal in Ontario. Seven health service providers with more than 10 presentations between them were accepted for the Expo. The two-day event presented a unique occasion for collectively acknowledging the system's successes around the delivery of patient-focused and integrated health care services. McMaster University's Department of Family Medicine was honoured by Minister Smitherman with one of six Innovation Awards. The P-Prompt project which boosts screening rates in Ontario for mammograms, pap testing, influenza vaccination and childhood primary vaccinations was presented with the Innovations in Health Information Management award.

Special Projects: Provincially Guided - Community Decided

Aging at Home Strategy

Our LHIN embraced the three-year Aging at Home strategy announced in August, 2007, and worked with stakeholders to allocate $7.1M to programs and services that promote healthy aging and independent living. In Year 1, new resources will be closing long standing gaps in day programs and caregiver support, and promoting peer support and intergenerational approaches for healthy families and communities to sustain quality of life for people as they get older.

In order to inform its recommendations to the Board, staff undertook two significant community engagement events to better understand the resources, needs and successes in the community. In mid-September approximately 30 community thought leaders from across the LHIN came together to share and discuss with the HNHB LHIN how best to move the Strategy forward in partnership with stakeholders and residents who together contribute to independent living. The roundtable was followed in October with a world café event that convened more than 130 health services providers and community members that provided the LHIN with key directions, priorities and focus areas as the planning year got underway.

'Let's Talk: Aging at Home' proved to be an innovative way to engage with our community. Let's Talk is a series of organized, small, informal conversations that provide valuable information to the HNHB LHIN as well as the participants, and communities with an interest in healthy aging. With 'Let's Talk: Aging at Home,' a wide range of people, including seniors, their families, their caregivers, and their health service providers joined in conversations about aging at home. These conversations are informing the direction the HNHB LHIN takes as it implements the Aging at Home Strategy.

Through 'Let's Talk: Aging at Home,' the HNHB LHIN is seeking to:

1. understand seniors' aspirations for health and well-being in their communities;
2. provide an opportunity for seniors to identify ideas they have to support their independence;
3. learn about successful programs and enablers throughout the broader HNHB LHIN community; and,
4. make informed decisions on the allocation of resources.

In late February 2007 the HNHB LHIN took part in a province-wide Innovations Exchange. Held via video conference the Innovations Exchange was designed to give all 14 LHINs and their communities an opportunity to showcase innovative approaches to support seniors' independent living and healthy aging at home. The HNHB LHIN, in collaboration with community leaders, hosted five sites across the LHIN and was also host to the Young Carers Initiative who presented their innovative project designed to support young people's health and well being as caregivers for elders at home with a chronic disease.

The Aging at Home Strategy is the local incubator for health system transformation. The collaboration and innovation potential for independent living and healthy aging at home in the 21st century is enormous. There are signs early in the strategy of new collaborations and readiness for new ways of work in Phase 2 to support aging at home in the HNHB LHIN. The full weight of the strategy to promote social inclusion, opportunities for under-employed persons, new partnerships, adoption of technologies, shared services, and robust volunteerism for health aging, is yet to be realized.

"It's exciting to see how our providers are shifting away from 'how can my organization make a difference' and moving toward 'how can our organizations work together to provide a continuum of care for people in our community.'"

—[illegible]

Emergency Department Action Plan

The Emergency Department Action Plan (EDAP) was the first funding decision made at the local level. $1.3 million in base funding was targeted by the Ministry to help the Niagara region reduce patient burden on its emergency departments.

A group of nine Niagara organizations or networks, representing more than 100 smaller organizations (ranging from long-term care homes to community support services, from hospitals to supportive housing) came together to develop a joint proposal. They focused on how to provide quality patient care in the community that would relieve pressures on hospitals and emergency departments. There were four criteria that they worked with:

- Expedite patient flow from hospital to community, reducing Alternate Level of Care and emergency department pressures;
- Enhance access to professional and community support services that enable frail seniors to live independently;
- Expand and co-ordinate Community Care Access Centre (CCAC) and community support services and improve system capacity to manage clients, primarily frail seniors with higher level needs; and,
- Enhance availability of case management available to hospital patients to enable faster access to community services.

Together they submitted one consensus based and area-wide endorsed basket of proposals. The proposals advanced a continuum of support and care to ensure right support in the right place.

The Home to Stay program was one of 10 initiatives approved by the HNHB LHIN Board. The program ensures the right mix of services are available in a timely manner to make discharges from hospital smoother and quicker. The Home to Stay program helps keep people at home and in the community with one or more of the following supports; congregate and supportive housing, community support services, adult day services, in-home care and service coordination.

LHIN Urgent Priority Fund

The LHIN Urgent Priority Fund (LUPF) took community decision making one step further. In this case, the Ministry provided the HNHB LHIN with $2.9 million for 2007/08 to address priorities identified in our Integrated Health Service Plan (IHSP) as well as emerging pressure points.

In addition to Health Service Improvement Plans (H-SIPs) for community priorities and emerging pressures, HNHB LHIN health service providers submitted proposals previously developed for the MOHLTC Regional Office for long-term pressure points.

All submissions were assessed against three principle criteria:

- benefit to the community;
- risk assessment; and,
- feasibility.

More than 30 health service providers submitted approximately 107 proposals to the HNHB LHIN. Over the course of four meetings, the Board allocated the $2.9 million to more than 40 community focused proposals.

The HNHB LHIN is excited about addressing the priorities established locally and is looking forward to measuring how funded initiatives improve health system effectiveness for best health outcomes in the LHIN.

Financial Statements of Hamilton Niagara Haldimand Brant Local Health Integration Network

March 31, 2008

Auditors' Report

To the Members of the Board of Directors of the
Hamilton Niagara Haldimand Brant Local Health Integration Network

We have audited the statement of financial position of the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") as at March 31, 2008 and the statements of financial activities, changes in net debt and cash flows for the year then ended. These financial statements are the responsibility of the LHIN's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with Canadian generally accepted auditing standards. Those standards require that we plan and perform an audit to obtain reasonable assurance whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation.

In our opinion, these financial statements present fairly, in all material respects, the financial position of the Hamilton Niagara Haldimand Brant Local Health Integration Network as at March 31, 2008 and the results of its operations, its changes in its net debt and its cash flows for the year then ended, in accordance with Canadian generally accepted accounting principles.

Deloitte & Touche LLP

Chartered Accountants

Licensed Public Accountants
Toronto, Ontario

May 2, 2008

Statement of Financial Position

As at March 31, 2008

	2008	2007
	$	$
Cash	780,017	677,583
Accounts receivable - Other	4,796	3,138
Due from the Ministry of Health and Long-Term Care ("MOHLTC") Health Service Providers ("HSPs") (Note 9)	6,898,982	-
Due from HSPs	1,018,000	-
	8,701,795	680,721
Accounts payable and accrued liabilities	770,201	603,806
Due to the MOHLTC (Note 3b)	4,531	-
Due to the MOHLTC from HSPs	1,018,000	-
Due to HSPs from MOHLTC (Note 9)	6,898,982	-
Due to the LHIN Shared Services Office (Note 4)	11,844	79,507
Deferred capital contributions (Note 5)	460,145	618,425
	9,163,703	1,301,738
Commitments (Note 6)		
	(461,908)	(621,017)
Non-financial assets		
Prepaid expenses	1,763	2,592
Capital assets (Note 7)	460,145	618,425
Accumulated surplus	-	-

Approved by the Board

Juanita G. Gledhill, Board Chair

Jack Brewer, Vice Chair

Statement of Financial Activities

Year ended March 31, 2008

	Budget (unaudited) (Note 8)	2008 Actual	2007 Acutal
		$	$
Revenue			
MOHLTC funding			
HSPs transfer payments (Note 9)	2,263,441,672	2,281,812,052	-
Operations of LHIN	4,028,420	3,961,793	3,625,620
E-Health (Note 10)	-	275,000	33,000
Wait List Management Activities (Note 10)	-	70,000	-
Aging at Home (Note 10)	-	295,000	-
Emergency Dept LHIN LEAD (Note 10)	-	43,800	-
Aboriginal Planning (Note 10)	-	52,500	-
Amortization of deferred capital contributions (Note 5)	-	224,907	206,651
	2,267,470,092	2,286,735,052	3,865,271
Expenses			
Transfer payments to HSPs (Note 9)	2,263,441,672	2,281,812,052	-
General and administrative (Note 11)	4,028,420	4,186,700	3,832,271
E-Health (Note 10)	-	275,000	33,000
Wait List Management Activities (Note 10)	-	70,000	-
Aging at Home (Note 10)	-	295,000	-
Emergency Dept LHIN LEAD (Note 10)	-	39,269	-
Aborigir l Planning (Note 10)	-	52,500	-
	2,267,470,092	2,286,730,521	3,865,271

Statement of Financial Activities *continued*

	Budget (unaudited) (Note 8)	2008 Actual	2007 Acutal
		$	$
Annual surplus before funding repayable to the MOHLTC	-	4,531	-
Funding repayable to the MOHLTC (Note 3a)	-	(4,531)	-
Annual surplus	-	-	-
Opening accumulated surplus	-	-	-
Closing Accumulated surplus	-	-	-

Statement of Changes in Net Debt

Year ended March 31, 2008

	2008	2007
	$	$
Annual surplus	-	-
Acquisition of capital assets	**(66,627)**	(145,561)
Amortization of capital assets	**224,907**	206,651
Change in other non-financial assets	**829**	(2,592)
Decrease in net debt	**159,109**	58,498
Opening net debt	**(621,017)**	(679,515)
Closing net debt	**(461,908)**	(621,017)

Statement of Cash Flows

Year Ended March 31, 2008

	2008	2007
	$	$
Operating		
Annual surplus	-	-
Add items not affecting cash		
Amortization of capital assets	**224,907**	206,651
Less items not affecting cash		
Amortization of deferred capital contributions (Note 5)	**(224,907)**	(206,651)
	-	-
Changes in non-cash operating items		
Increase in accounts receivable	**(1,658)**	(3,138)
Increase in due from MOHLTC to HSPs	**(6,898,982)**	-
Increase in due from HSPs	**(1,018,000)**	-
Decrease (increase) in prepaid expenses	**829**	(2,592)
Increase in accounts payable and accrued liabilities	**166,395**	603,806
Decrease in due to the LHIN Shared Services Office	**(67,663)**	79,507
Increase (decrease) in due to MOHLTC	**4,531**	(30,351)
Increase in due to MOHLTC from HSPs	**1,018,000**	-
Increase in due to HSPs from MOHLTC	**6,898,982**	-
	102,434	647,232
Capital transactions		
Acquisition of capital assets	**(66,627)**	(145,561)
Financing transactions		
Increase in deferred capital contributions (Note 5)	**66,627**	145,561
Net increase in cash	**102,434**	647,232
Cash, beginning of year	**677,583**	30,351
Cash, end of year	**780,017**	677,583

Notes to the Financial Statements

1. Description of business

The Hamilton Niagara Haldimand Brant Local Health Integration Network was incorporated by Letters Patent on June 2, 2005 as a corporation without share capital. Following Royal Assent to Bill 36 on March 28, 2006, it was continued under the Local Health System Integration Act, 2006 (the "Act") as the Hamilton Niagara Haldimand Brant Local Health Integration Network (the "LHIN") and its Letters Patent were extinguished. As an agent of the Crown, the LHIN is not subject to income taxation.

The LHIN is, and exercises its powers only as, an agent of the Crown. Limits on the LHIN's ability to undertake certain activities are set out in the Act.

The LHIN has also entered into an Accountability Agreement with the Ministry of Health and LongTerm Care ("MOHLTC"), which provides the framework for LHIN accountabilities and activities.

Commencing April 1, 2007, all funding payments to LHIN managed health service providers in the LHIN geographic area, have flowed through the LHIN's financial statements. Funding allocations from the MOHLTC are reflected as revenue and an equal amount of transfer payments to authorized Health Service Providers ("HSP") are expensed in the LHIN's financial statements for the year ended March 31, 2008.

The mandates of the LHIN are to plan, fund and integrate the local health system within its geographic area. The LHIN spans carefully defined geographical areas and allows for local communities and health care providers within the geographical area to work together to identify local priorities, plan health services and deliver them in a more coordinated fashion. The LHIN covers the Counties of Hamilton, Niagara, Haldimand, Brant, most of the County of Norfolk and the City of Burlington. The LHIN enters into service accountability agreements with service providers.

2. Significant accounting policies

The financial statements of the LHIN are the representations of management, prepared in accordance with Canadian generally accepted accounting principles for governments as established by the Public Sector Accounting Board ("PSAB") of the Canadian Institute of Chartered Accountants ("CICA") and, where applicable, the recommendations of the Accounting Standards Board ("AcSB") of the CICA as interpreted by the Province of Ontario. Significant accounting policies adopted by the LHIN are as follows:

Revenues and expenses are reported on the accrual basis of accounting. The accrual basis of accounting recognizes revenues in the fiscal year that the events giving rise to the revenues occur and they are earned and measurable; expenses are recognized in the fiscal year that the events giving rise to the expenses are incurred, resources are consumed, and they are measurable.

Through the accrual basis of accounting, expenses include non-cash items, such as the amortization of capital asset and losses in the value of assets.

The LHIN is funded solely by the Province of Ontario in accordance with the Ministry LHIN Accountability Agreement ("MLAA"), which describes budget arrangements established by the MOHLTC. These financial statements reflect agreed funding arrangements approved by the MOHLTC. The LHIN cannot authorize an amount in excess of the budget allocation set by the MOHLTC.

The LHIN assumed responsibility to authorize transfer payments to HSPs, effective April 1, 2007. The transfer payment amount is based on provisions associated with the respective HSP Accountability Agreement with the LHIN. Throughout the fiscal year, the LHIN authorizes and notifies the MOHLTC of the transfer payment amount; the MOHLTC, in turn, transfers the amount directly to the HSP. The cash associated with the transfer payment does not flow through the LHIN bank account.

The LHIN statements do not include any Ministry managed programs.

Government transfer payments from the MOHLTC are recognized in the financial statements in the year in which the payment is authorized and the events giving rise to the transfer occur, performance criteria are met, and reasonable estimates of the amount can be made.

Certain amounts, including transfer payments from the MOHLTC, are received pursuant to legislation, regulation or agreement and may only be used in the conduct of certain programs or in the completion of specific work. Funding is only recognized as revenue in the fiscal year the related expenses are incurred or services performed. In addition, certain amounts received are used to pay expenses for which the related services have yet to be performed. These amounts are recorded as payable to the MOHLTC at period end.

Any amounts received that are used to fund expenditures that are recorded as capital assets, are recorded as deferred capital contributions and are recognized over the useful life of the asset reflective of the provision of its services. The amount recorded under "revenue" in the Statement of Financial Activities, is in accordance with the amortization policy applied to the related capital asset recorded.

Capital assets are recorded at historical cost. Historical cost includes the costs directly related to the acquisition, design, construction, development, improvement or betterment of capital assets. The cost of capital assets contributed is recorded at the estimated fair value on the date of contribution. Fair value of contributed capital assets is estimated using the cost of asset or, where more appropriate, market or appraisal values. Where an estimate of fair value cannot be made, the capital asset would be recognized at nominal value.

Maintenance and repair costs are recognized as an expense when incurred. Betterments or improvements that significantly increase or prolong the service life or capacity of a capital asset are capitalized. Computer software is recognized as an expense when incurred.

Capital assets are stated at cost less accumulated amortization. Capital assets are amortized over their estimated useful lives as follows:

Computer equipment	3 years straight-line method
Leasehold improvements	Life of lease straight-line method
Office equipment, furniture and fixtures	5 years straight-line method
Infrastructure/web development	3 years straight-line method

For assets acquired or brought into use during the year, amortization is calculated for a full year. Infrastructure/web development costs are included with computer equipment for accounting and reporting purposes.

The preparation of financial statements in conformity with Canadian generally accepted accounting principles requires management to make estimates and assumptions that affect the reported amount of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Actual results could differ from those estimates.

3. Funding repayable to the MOHLTC

In accordance with the MLAA, the LHIN is required to be in a balanced position at year end. Thus, any funding received in excess of expenses incurred, is required to be returned to the MOHLTC.

a) The amount repayable to the MOHLTC related to current year activities is made up of the following components:

	Revenue	Expenses	Surplus
	$	$	$
Transfer payments to HSPs	2,281,812,052	2,281,812,052	-
LHIN operations	4,186,700	4,186,700	-
E-Health	275,000	275,000	-
Wait List Management Activities	70,000	70,000	-
Emergency Department LHIN LEAD	43,800	39,269	4,531
Aboriginal Planning	52,500	52,500	-
Aging at Home	295,000	295,000	-
	2,286,735,052	2,286,730,521	4,531

b) The amount due to the MOHLTC at March 31, 2008 is made up as follows:

	$
Due to MOHLTC, beginning of year	-
Funding repayable related to current year activities to the MOHLTC (Note 3a)	4,531
Due to MOHLTC, end of year	4,531

4. Related party transactions

The LHIN Shared Services Office (the "LSSO") is a division of the Toronto Central LHIN and is subject to the same policies, guidelines and directives as the Toronto Central LHIN. The LSSO, on behalf of the LHINs is responsible for providing services to all LHINs. The full costs of providing these services are billed to all the LHINs on an equal basis. Any portion of the LSSO operating costs overpaid (or not paid) by the LHINs at the year end, are recorded as a receivable (payable) to the LSSO. This is all done pursuant to the shared services agreement the LSSO has with all the LHINs.

5. Deferred capital contributions

	2008	2007
	$	$
Balance, beginning of year	**618,425**	679,515
Capital contributions received during the year	**66,627**	145,561
Amortization for the year	**(224,907)**	(206,651)
Balance, end of year	**460,145**	618,425

6. Commitments

The LHIN has commitments under various operating leases related to building and equipment. Lease renewals are likely. Minimum lease payments due in each of the next three years and thereafter are as follows:

	$
2009	153,850
2010	151,300
2011	48,896

The LHIN also has funding commitments to HSPs associated with accountability agreements.

7. Capital assets

			2008	2007
	Cost	Accumulated amortization	Net book value	Net book value
	$	$	$	$
Office equipment, furniture and fixtures	**305,082**	**151,973**	**153,109**	175,982
Computer equipment	**85,934**	**48,928**	**37,006**	38,300
Leasehold improvements	**670,566**	**400,536**	**270,030**	404,143
	1,061,582	**601,437**	**460,145**	618,425

8. Budget figures

The budgets were approved by the Government of Ontario. The budget figures reported on the Statement of Financial Activities reflect the initial budget at April 1, 2007. The figures have been reported for the purposes of these statements to comply with PSAB reporting requirements. During the year the government approves budget adjustments. The following reflects the adjustments for the LHIN during the year:

The total HSP funding budget of $2,281,812,052 is made up of the following:

	$
Initial budget	2,263,441,672
Adjustment due to announcements made during the year	18,370,380
Total budget	2,281,812,052

The total operating budget of $4,764,720 is made up of the following:

	$
Initial budget	4,028,420
Additional funding received during the year for:	
E-Health	275,000
Wait List Management Activities	70,000
Aging at Home	295,000
Emergency Department LHIN LEAD	43,800
Aboriginal Planning	37,500
Aboriginal Planning (Funding from other LHINs)	15,000
	4,764,720

9. Transfer payments to HSPs

The LHIN has authorization to allocate funding of $2,281,812,052 to the various HSPs in its geographic area. The LHIN approved transfer payments to the various sectors in 2008 as follows:

	$
Operation of hospitals	1,599,087,005
Grants to compensate for municipal taxation - public hospitals	462,075
Long term care homes	356,860,092
Community care access centres	203,404,489
Community support services	35,241,082
Assisted living services in supportive housing	22,102,042
Community health centres	9,060,688
Community mental health addictions program	55,594,579
	2,281,812,052

The LHIN receives money from the MOHLTC which it in turn allocates to the HSPs. As at March 31, 2008, an amount of $6,898,982 was receivable from the MOHLTC and $6,898,982 was payable to the HSPs. These amounts have been reflected as revenue and expenses with the LHIN's financial activities and are included above.

The LHIN did not authorize any funding to HSPs in 2007.

10. a) E-Health

During fiscal 2008, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $275,000 (2007 - $33,000). These funds were used toward initiatives in support of its strategic e-Health Plan as defined in its Integrated Health Services Plan.

b) Wait List Management Activities

During fiscal 2008, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $70,000 (2007 - nil). As directed by the MOHLTC, these funds were used to improve data quality of the wait list for total joint surgery at Niagara Health System.

c) Aging at Home

During fiscal 2008, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $295,000 (2007 – nil). These funds were used for planning activities to support the Aging at Home strategy.

	$
Salaries and benefits	186,584
Director's per diems	4,025
Travel	2,573
Consulting services	62,395
Meeting expenses	10,263
Supplies, equipment, printing, other	29,160
	295,000

Included in total travel expenses of $2,573 is $855 of travel expenses incurred by the Board of Directors.

d) Emergency Department LHIN LEAD

During fiscal 2008, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $43,800 (2007 – nil). These funds were used toward initiatives in support of Emergency Department LHIN LEAD activities.

e) Aboriginal Planning

During fiscal 2008, the Hamilton Niagara Haldimand Brant LHIN received funding in the amount of $52,500 (2007 - nil). These funds were used to support Aboriginal Planning activities.

	$
Salaries and benefits	6,124
Travel	3,159
Consulting services	18,506
Meeting expenses	21,657
Supplies, other	3,054
	52,500

11. General and administrative expenses

The Statement of Financial Activities presents the expenses by function, the following classifies these same expenses by object:

	2008	2007
	$	$
Salaries and benefits	2,443,819	1,421,781
Director's per diems	126,200	148,926
Travel	73,795	79,986
Consulting services	325,433	677,334
Banking services	102	673
Community forums & communication	118,764	305,944
Supplies, equipment, maintenance, other	340,805	425,068
Accommodation	232,875	267,850
Amortization	224,907	206,651
Shared services	300,000	290,201
Conflict of interest (COI)	-	7,857
	4,186,700	3,832,271
E-Health funding	275,000	33,000
Wait List Management Activities funding	70,000	-
Aging at Home funding	295,000	-
Emergency Department LHIN LEAD funding	39,269	-
Aboriginal Planning	52,500	-
	4,918,469	3,865,271

Reconciliation to MOHLTC approved budget:	
General and administrative expenses	4,918,469
Less: amortization	(224,907)
Add: purchase of tangible capital assets	66,627
Add: funding repayable to the MOHLTC	4,531
	4,764,720

Included in total travel expenses of $73,795 is $18,557 of travel expenses incurred by the Board of Directors.

12. Pension agreements

The LHIN makes contributions to the Hospitals of Ontario Pension Plan ("HOOPP"), which is a multi-employer plan, on behalf of 23 members of its staff. The plan is a defined benefit plan, which specifies the amount of retirement benefit to be received by the employees, based on the length of service and rates of pay. The amount contributed to HOOPP for fiscal 2008 was $169,704 (2007 - $68,532) for current service costs and is included as an expense in the Statement of Financial Activities.

13. Guarantees

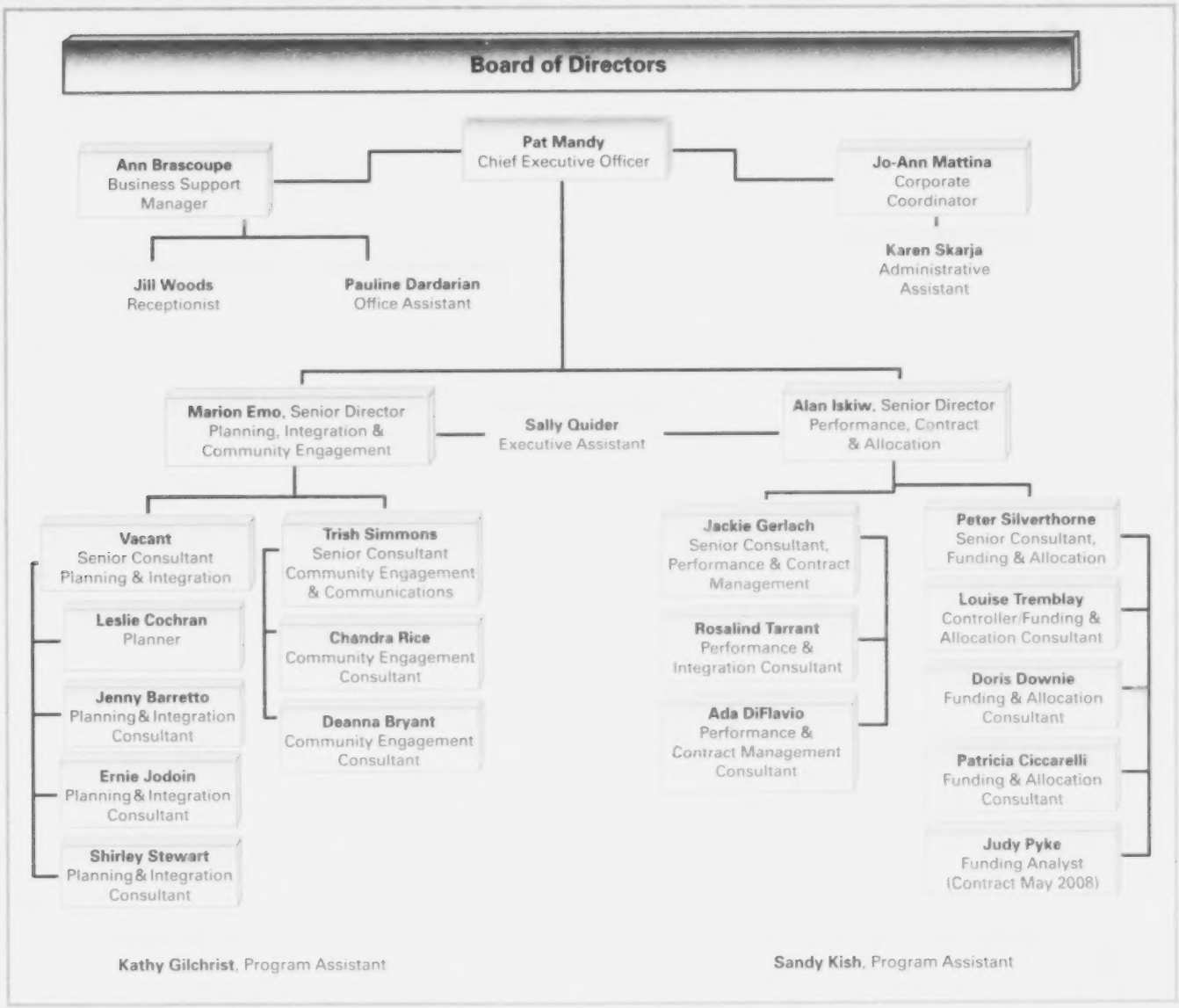
The LHIN is subject to the provisions of the Financial Administration Act. As a result, in the normal course of business, the LHIN may not enter into agreements that include indemnities in favour of third parties, except in accordance with the Financial Administration Act and the related Indemnification Directive.

An indemnity of the Chief Executive Officer was provided directly by the LHIN pursuant to the terms of the Local Health System Integration Act, 2006 and in accordance with s. 28 of the Financial Administration Act.

14. Segment disclosures

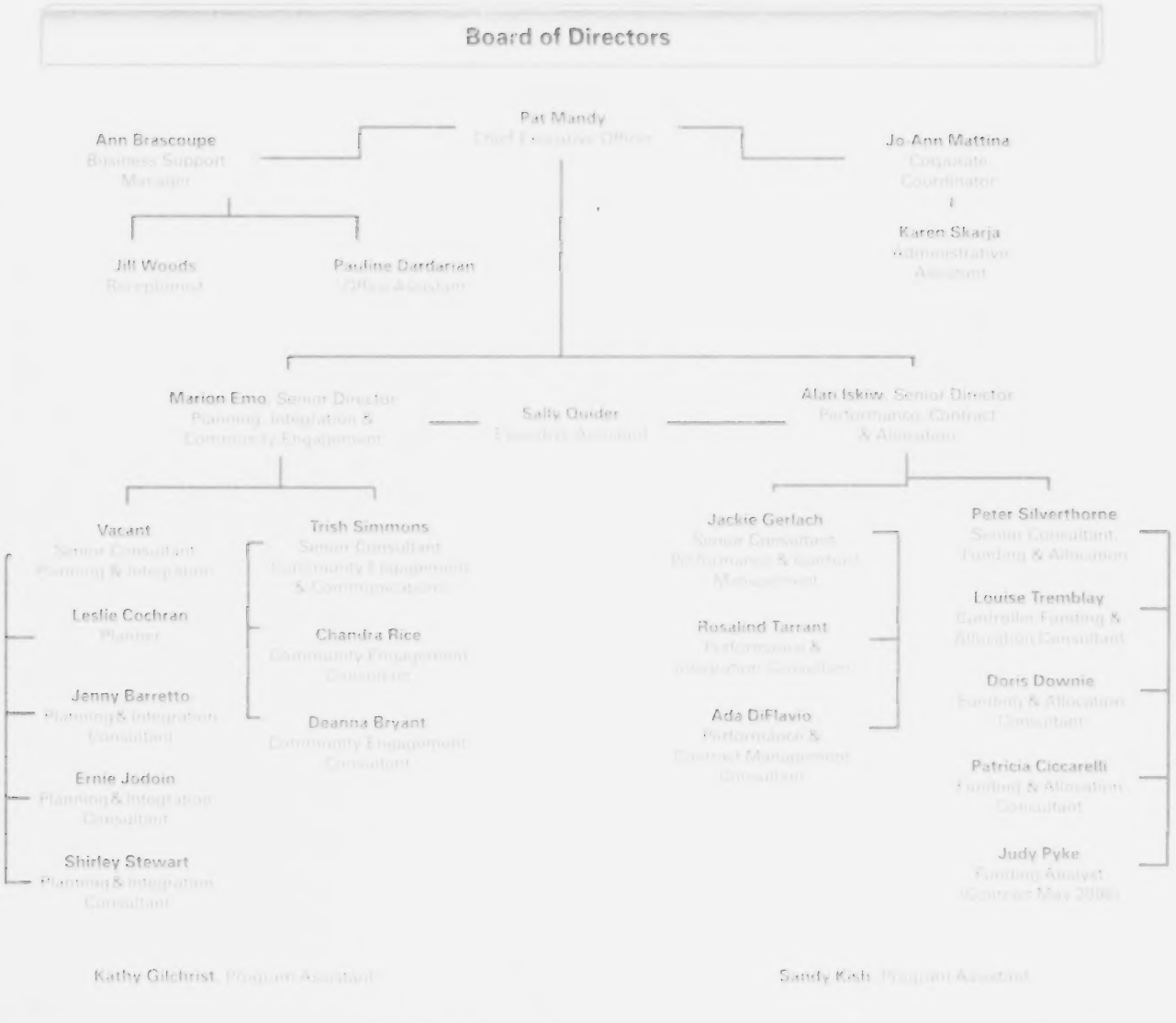
The LHIN was required to adopt Section PS 2700 - Segment Disclosures, for the fiscal year beginning April 1, 2007. A segment is defined as a distinguishable activity or group of activities for which it is appropriate to separately report financial information. Management has determined that existing disclosures in the Statement of Financial Activities and within the related notes for both the prior and current year sufficiently discloses information of all appropriate segments and therefore no additional disclosure is required.

HNHB LHIN Organization Chart



As of March 31, 2008

HNHB LHIN Organization Chart



As of March 31, 2008

Board Members

Juanita G. Gledhill
Chair

Jack Brewer
Vice-Chair

Douglas Archibald
Board Member

Stephen Birch
Board Member

Carolyn King
Board Member

William (Bill) McLean
Board Member

William (Bill) Millar
Board Member

Janice Mills
Board Member

Senior Staff Members

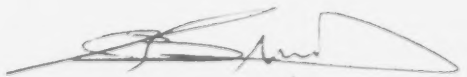
Pat Mandy
Chief Executive Officer

Alan Iskiw
Senior Director,
Performance, Contract and Allocation

Marion Emo
Senior Director,
Planning, Integration and Community Engagement

On behalf of the Board of Directors of the Hamilton Niagara Haldimand Brant Local Health Integration Network, we are pleased to submit this Annual Report for the period ended March 31, 2008.

Juanita G. Gledhill,
Chair, Board of Directors



Jack Brewer
Vice-Chair, Board of Directors

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